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WILLIAM T FUJIOKA
Chief Executive Officer

September 10, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

STATUS REPORT ON HEALTH MANAGEMENT ASSOCIATES RECOMMENDATIONS FOR NEGOTIATIONS WITH L.A. CARE AND FOR AMBULATORY CARE RESTRUCTURING (ITEM NO. 39, AGENDA OF SEPTEMBER 14, 2010)

On April 13, 2010, your Board approved, in concept, the report and recommendations by Health Management Associates (HMA) on its evaluation of the Department of Health Services (DHS) Office of Managed Care (OMC)/Community Health Plan (CHP) and its readiness for pending health reform changes. In addition, your Board approved this Office convening: 1) DHS and L.A. Care representatives to engage in negotiations to determine whether the new relationship, as outlined in the HMA report, can be developed; and 2) workgroups to develop an implementation plan, with specific timelines and projected costs, to address the recommendations in the HMA report. Further, your Board instructed this Office to report back at a regularly scheduled Board meeting every 30 to 60 days with a status regarding the negotiations with L.A. Care.

This memorandum provides our second status report on the status of the negotiations with L.A. Care and the DHS ambulatory care restructuring efforts. In addition, this report responds to the request by your Board on July 13, 2010, for a transformation plan that will be required in accordance with the HMA report to fulfill the commitments made in the State Waiver proposal and to meet the requirements of health reform. Additional information will be provided regarding commitments consistent with the State Waiver proposal once the terms and conditions of the Waiver are known.

This report is scheduled for discussion at your Board's September 14, 2010 meeting.

L.A. Care Negotiations

The County and L.A. Care representatives are conducting weekly conference calls to monitor progress on five main areas: scope of the project (which product lines will be considered, e.g., Medi-Cal Managed Care, Healthy Families, In-Home Supportive Services Worker Healthcare Plan); transition/operational issues; employee issues; financial considerations; and stakeholder involvement. Key areas are discussed further below. The County and L.A. Care representatives have also developed guiding principles for the negotiations (Attachment I).

The DHS ambulatory care restructuring effort is also important to the L.A. Care negotiations; therefore, updates are provided during the regular calls as needed. Most recently, as part of its update and consistent with the recommendations in the HMA report, CEO and DHS representatives requested that L.A. Care consider providing resources for several key elements of the restructuring plan: project management to support the ambulatory care restructuring; technical assistance and training to support implementation of medical homes; and public relations/communications consultation. That request is currently in discussion.

On August 16, 2010, the County entered into an Agreement with Macias Gini & O'Connell LLP (MGO), an independent audit firm, to conduct the financial review of the DHS CHP, as proposed by the HMA report.

- The scope of work for the MGO review was jointly developed by the County and L.A. Care, to be referenced in the upcoming negotiations.

- The Auditor-Controller convened an entrance conference meeting on August 18, 2010, between representatives of both the County and L.A. Care to review the major objectives outlined in the scope of work and identify contacts participating in the engagement.

- Weekly status reports are being provided to monitor progress.

- MGO will provide the County and L.A. Care with their final report by September 30, 2010. A copy of the final report will be provided to your Board shortly after final review.

In addition, the County/L.A. Care representatives are developing a plan for stakeholder and community education, outreach and involvement, both during this negotiation phase and, as needed, for future implementation, should the proposed partnership with L.A. Care be recommended to and approved by your Board. In addition to the members

of your Board and of the L.A. Care Board, other stakeholders include the provider community, labor, advocates, and private funding organizations, among others. Our next written report on the L.A. Care negotiations will be provided in October 2010, with the next presentation at a regularly scheduled Board meeting planned for the end of November 2010.

Ambulatory Care Restructuring

On July 14, 2010, the DHS Ambulatory Care Restructuring Steering Committee completed a series of meetings, facilitated by the HMA consultants, to develop the guiding vision and principles for a restructured DHS ambulatory care system. Attachment II is the report from the Steering Committee. Since that time, the Steering Committee has continued to meet, as a full group and in smaller workgroups, to further develop the elements of the restructuring plan.

The DHS approach for this transformed system is to become a provider of choice for its defined population by assuring patient-centered quality care, providing sufficient capacity, integrating care coordination, achieving efficient operations, and meeting the requirements of health reform efforts.

The initial implementation work plan in the report reflects the changes which the Steering Committee believes are needed to achieve this vision, including:

- A newly created, elevated and expanded division in DHS to oversee ambulatory and managed care services.
- Identified Medical Homes to function as the central point for coordinated care for a defined population of approximately 400,000 – 450,000 patients (including PPPs); develop and initiate Medical Home training collaborative within the DHS system.
- Timely and appropriate access to primary and specialty outpatient care services.
- Assessment of diagnostic and ancillary capacity throughout the DHS system.
- Integration of Management Services Organization (MSO) functions.

In addition to the priorities noted above, DHS will seek to: implement a standardized staffing model consistent with managed care; evaluate short- and long-term information technology solutions; actively pursue pilot projects with the Departments of Mental Health and Public Health to integrate medical and behavioral health services;

and assess its current medical school and Public Private Partnership agreements to engage the medical schools and community clinics in discussions about their partnership roles in the DHS ambulatory care restructuring and readiness for health reform implementation. Likewise, a comprehensive communications plan, both internally and externally, will be vitally important as transformation progresses.

In order to immediately begin to move towards this transition, DHS will need to identify an interim central leadership team to fully develop the concept of the ambulatory care structure and the proposed permanent management positions and accountability structure for the restructured ambulatory care services. The interim central leadership team should include both uniquely qualified DHS staff and non-County individuals with extensive experience in developing and implementing ambulatory care and managed services organizations. It is currently anticipated that these individuals would be dedicated full-time to this effort for approximately four to six months, until the permanent positions can be developed and approved by your Board, and permanent appointments made to them.

Unless otherwise instructed by your Board, DHS leadership will proceed with efforts to identify qualified DHS candidates for the interim central leadership team and, as noted above, DHS and CEO representatives will continue to pursue the request to L.A. Care to provide project management resources, including a Project Manager who would have oversight responsibility to ensure progress on all elements of the DHS ambulatory care restructuring proposal, over the next 12 to 24 months or longer, as needed.

The next status report on the ambulatory care restructuring plan is planned for November 2010.

Delegated Authority Agreement with HMA

In order to provide additional resources to facilitate the County's negotiations with L.A. Care and to assist DHS in the development of key elements of the ambulatory care restructuring plan, this Office executed an amendment to extend the current Delegated Authority Agreement with HMA.

The scope of work includes: 1) provide support, at the County's direction, in restructuring the DHS ambulatory health care system, with the work plan developed by DHS leadership in transforming to a comprehensive and coordinated managed care delivery system; 2) serve as support in the assessment of the PPP relationship between DHS and the community clinics to assure that the clinics are included as partners in managing the care of the DHS patient population and of the medical school agreements; 3) provide continued support and direction to the new ambulatory

leadership team and the DHS Ambulatory Care Restructuring Steering Committee; and 4) provide project management support and facilitation to the County in the negotiations with L.A. Care. The amendments extended the term of the Agreement to December 31, 2010, at an increased cost of $264,264 for the additional scope of work. Under the terms of the Agreement, HMA will provide the County with a status on the progress of the implementation plan for DHS ambulatory restructuring by November 1, 2010. This report will be included in the next status report on the ambulatory care restructuring plan.

Please let me know if you have questions or your staff may contact Sheila Shima, Deputy Chief Executive Officer, at (213) 974-1160.

WTF:BC:SAS
MLM:DL:gl

Attachments

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Mental Health
Public Health

Attachment I

LA County and L.A. Care Managed Care Partnership

Guiding Principles- Final Draft 09/10/10

Objective:

To develop a new, mutually beneficial partnership between Los Angeles County and L.A. Care to support the collaboration required to realize a shared vision of system delivery transformation in Los Angeles County that ensures access to quality health care services for Los Angeles County's low income and underserved residents, assures readiness for significant expansion of Medicaid eligibles who will likely be enrolled in managed care plans and supports the public and private safety net.

Guiding Principles:

The following are a set of guiding principles to facilitate and determine the success of the negotiation process and the development of a strategic partnership agreement between Los Angeles County Department of Health Services (LACDHS) and L.A. Care.

Integrated Safety Net Delivery System

- Strengthen and enhance the current safety net delivery system in LA County to prepare for the implementation of national health care reform and the State's new Medicaid Section 1115 waiver.
- Building on the LACDHS System, develop coordinated and integrated provider networks including with private safety net hospitals to optimize the delivery of care across the entire continuum of services (primary, specialty, ancillary and inpatient).
- Restructure LACDHS' current relationship with Public Private Partner (PPP) clinics to better align financial and clinical incentives and integrate them as primary care providers into the LACDHS delivery system.

Managed Care Infrastructure

- Build the necessary infrastructure within the LACDHS delivery system to ensure readiness to participate in expanded opportunities under federal health care reform and the State's new Medicaid 1115 waiver.
- Provide LACDHS with resource, technical assistance and financial investments to support the development and sustainability of a robust, integrated delivery system to more effectively

provide services to current government sponsored beneficiaries and additional covered populations as a result of national health care reform and the State's new 1115 waiver.

- Work in collaboration to ensure LA County is poised to guarantee access and availability of services for the expected increase of SPD Medi-Cal beneficiaries enrolled in managed care, as well as other targeted populations that will likely be transitioned to managed care.
- Develop a partnership L.A. Care/ LACDHS managed care unit to facilitate and support the development of managed care infrastructure and capabilities within the LACDHS system and promotion of LACDHS facilities and providers within L.A. Care.
- Address contracting barriers within the LA County system to increase new sources of paying patients served by the LACDHS delivery system.

Innovation

- Through new partnership arrangement, design and implement new models of care to ensure access, quality and cost efficiencies for SPD and other Medi-Cal beneficiaries (i.e. children with special health care needs andpersons with serious mental illness) that will likely be transitioning to organized systems of care under the State's 1115 waiver.
- Look for new opportunities to work with the State, policy makers, providers, the community and other stakeholders to develop innovative and collaborative models of care and strategies to bend the cost curve and improve quality and health outcomes for vulnerable populations with complex and high-cost needs.

Retention and Growth

- At minimum, maintain the current level of Medi-Cal managed care, Healthy Families and PASC-SEIU Homecare Worker Health Care Plan assignees within the LACDHS system to enable the county safety net to provide services to other underserved and uninsured populations.
- Maintain Healthy Families Community Provider Plan status and continuity of care for In Home Supportive Services (IHSS) covered workers under the new partnership arrangement.
- Develop the necessary administrative infrastructure, managed care capabilities and expertise within LACDHS delivery system to retain its current patient base and effectively compete for new patients under new contractual relationships with LA Care and its Plan Partners to provide services to Medi-Cal managed care beneficiaries; coverage expansions under national health care reform, and the movement of fee-for-service Medi-Cal beneficiaries into more organized systems of care under the State's new 1115 waiver.

Financial Viability

- Collaborate to help to assure the fiscal stability and sustainability of LA County's safety net delivery system.
- Assure new provider payment and/or reimbursement structures to LACDHS that accurately reflect the cost of providing services and does not result in a reduction in current revenue to LA County as a result of the new partnership arrangement.

Engagement, Accountability and Transparency

- Assure active engagement of LA County and L.A. Care's executive leadership teams and boards to achieve a shared vision of a new integrated partnership model based upon trust, open communication, transparency and accountability.

- Develop and institute an agreed upon decision making process that specifies the decision rights and accountability framework for the negotiation process and partnership agreement that respects the management culture of both organizations.
- Develop benchmarks, milestones and timelines to monitor and report progress of partnership negotiations and the effectiveness of new integrated partnership if an agreement is successfully reached.
- Make all efforts to involve labor in the transition process that will result in this new partnership.
- Develop a transition plan that is seamless to impacted members and ensures their continued access to quality health care.

Attachment II

TRANSFORMING DHS:

THE RESTRUCTURING OF AMBULATORY AND MANAGED CARE SERVICES WITHIN THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

Work Plan of the DHS Ambulatory Care Restructuring Steering Committee

Carol Meyer, DHS (Chair)
Mindy Aisen, MD, Rancho Los Amigos
James Gerson, MD, Office of Managed Care
Jeff Guterman, MD, DHS
Stephanie Hall, MD, LAC+USC Network
Dennis Levin, MD, MetroCare/Ambulatory
Gretchen McGinley, DHS
Miguel Ortiz-Marroquin, Metrocare/Harbor-UCLA
Tim Moore, ValleyCare/High Desert MACC
Cynthia Moore-Oliver, MetroCare/MLK MACC
Marianna Pacheco, LAC+USC Network/Specialty Clinics
Carolyn Rhee, ValleyCare/Olive View Medical Center
Gregory Roybal, MD, LAC+USC Network/CHC
Cheri Todoroff, DHS
Behnaz Hekmantia (Staff)

Health Management Associates

Terry Conway, MD, Managing Principal
Pat Terrell, Managing Principal

JULY 16, 2010

Context

In April, 2010, the Los Angeles County Board of Supervisors instructed the Office of the CEO and the Los Angeles County Department of Health Services (DHS) to initiate a process that will result in a robust DHS ambulatory system, integrated with managed care services that support the full delivery system. This restructuring is critical to assure the County's readiness for the renewal of the California 1115 Medicaid Waiver and national health reform, both of which will result in moving large numbers of patients currently cared for by the County into coverage, predominately into a managed care environment. If DHS does not transition from an episodic care focus for all to a planned delivery system for a defined population who will have a choice of providers, it risks losing those patients who contribute financially to DHS operations.

This effort is timely and aggressive; the changes in the approach to caring for many of the existing patients in DHS will begin with the conversion of some complex Medi-Cal patients--Seniors and Persons with Disabilities (SPDs)--into managed care by early 2011 and the proposed significant increase in uninsured patients included in the Coverage Initiative (which is being shaped as a transition to the expansion of Medicaid eligibility under Health Reform in 2014) may begin this fall. All of these changes will require a focused new emphasis on a strong and comprehensive ambulatory system to manage patient care, to minimize unnecessary Emergency Department (ED) and inpatient admissions and to reduce the Length of Stay (LOS) in DHS' hospitals that are due to the inability to secure a medical home for patients upon discharge. These changes represent the greatest change in health care coverage and organization in more than a generation and they will require a major shift in the focus and organization of DHS.

Approach

A Steering Committee of DHS CEOs, medical leaders, ambulatory care practitioners, and DHS senior staff was named and, facilitated by Health Management Associates (HMA), has developed both a vision of what the new approach to ambulatory and managed care will look like within DHS and a framework and timeline for the transformation's implementation. This effort has been—and will continue to be--a "forced march" to move quickly and thoughtfully and in full recognition of the challenges of accomplishing major change within the current structure. It is the conviction of all of the participants in the process that this work is a priority for both the future of the Department and, more importantly, for the preservation of the health care safety net for the vulnerable residents and communities of Los Angeles County.

Guiding Vision and Principles

The Steering Committee agreed upon the following Vision and Principles for a restructured DHS ambulatory care system:

Vision Statement

The Los Angeles County Department of Health Services (DHS) ambulatory health care system—made up of those services that it provides directly, those it funds and the providers with which it partners--will become a provider of choice for its defined population by:

- assuring patient-centered quality care, thereby contributing to a documentable improvement of health status;
- providing sufficient capacity and, at the same time, addressing barriers to access to assure that demand is met;
- integrating with other levels of the health system to effectively manage, through continuity and coordination, the delivery of care;
- operating efficiently in order to be accountable for cost; and
- serving as the entry point into the DHS delivery system in order to meet the requirements of national and state reform efforts that will demand comprehensive and managed, not episodic, care for a defined population .

Principles

1. Changes in Medi-Cal and national health reform will greatly expand health care coverage while providing a reimbursement mechanism that requires comprehensive management of care for individuals as well as for whole populations.
2. Disregarding the changes to Medi-Cal and national health reform will be deleterious to the DHS delivery system and, as important, to the population it serves.
3. DHS ambulatory care resources should be planned and prioritized based on capacity and the service needs of the defined population.
4. DHS ambulatory care should plan, request, advocate for and, if needed, build the infrastructure necessary for effectively managing the care of the defined patient population.

5. DHS ambulatory care should hold as high a priority and status within the delivery system as that held by other elements of the system, such as hospitals.

6. Each patient member of the DHS delivery system's defined population should have a Patient Centered Medical Home.

7. The elements of DHS ambulatory care should be built on a firm commitment to customer service and include: primary care Medical Homes, outpatient specialty care consultation, urgent care, outpatient procedures and surgeries, outpatient diagnostics, care management, rehabilitation, pharmacy services, information management and technology, and human resource management.

8. DHS ambulatory care should manage and direct human resources, time, physical space and equipment, and budget related to all its elements.

9. DHS ambulatory care should negotiate, refine and maintain partnerships with Public Private Partners (PPPs) and other community-based services, and assure their inclusion in managing the care of patients and populations.

10. DHS ambulatory care should set expectations, negotiate and contract with, and monitor the performance of relevant physicians, practice groups and medical colleges and other professional schools that provide services for the defined population.

11. DHS ambulatory care should play the leading role in assuring the cost and quality outcomes for the defined population served by DHS.

12. DHS ambulatory care should serve to draw the defined patient population into primary care and aggressively support the transition of patients out of higher levels of care back into ambulatory and primary care.

13. DHS ambulatory care should be overseen through a coordinated structure with clear and consistent expectations.

14. DHS ambulatory care should have a mechanism that is closely aligned, collaborates with and supports the efforts of other DHS, DMH and Public Health organizations and programs.

15. DHS should determine its defined patient population and that defined population should be agreed to by the BOS.

16. DHS ambulatory care should be led by people with experience and expertise in large system ambulatory care services and should be staffed by managers trained to meet the challenges of operating such an ambulatory care system.

17. DHS ambulatory care should be based on a clear staffing plan (centered on team-based care) and population-focused productivity expectations, with training and education provided to be able to meet those expectations.

18. DHS ambulatory care should be planned in cooperation with the other components of the system to assure synergies and avoid isolation.

19. DHS ambulatory care should work closely with finance to assure that incentives are, whenever possible, designed to support best practices and sound patient management.

20. DHS ambulatory care should provide a better experience for physicians in training, as the "real world" will be much more managed and ambulatory care focused than most students and residents receive within DHS today.

What Must be Done to Achieve This Vision?

The following are the key issues to be addressed, within the next year, in the restructuring of the ambulatory and managed care services within DHS:

- Create, elevate and expand a "division" within DHS to oversee its ambulatory and managed care services. This division would significantly alter the current DHS Table of Organization, with the leadership of the restructured entity at the level of their hospital counterparts. Specifically, the unit would:

    - provide centralized leadership and accountability for the development and maintenance of a strong and well-directed ambulatory service within the DHS system (although certain functions-to be defined-could be delegated to either existing regional networks or other structures for implementation);

    - establish and implement an ambulatory staffing model based on best practices and assuring productivity and effective care;

- assure accountability to and collaboration with the other components of the DHS system-reinforced by an organizational structure that maximizes interaction of ambulatory and hospital leadership at the system level in both planning and problem-solving-- to assure continuity of care and efficient use of resources;

- determine the scope of diagnostic and ancillary services needed to support the ambulatory system, assure that current services are utilized to maximum efficiency, and plan for assuring access to additional capacity as needed;

- control ambulatory budgets, space and resources;

- provide for system-wide support and education to ambulatory services to assure best practices and patient-centered care (i.e., Rancho Los Amigos should train all centers on the effective care of patients with disabilities);

- define the scope of services to be offered to those who seek and require only episodic care;

- provide the leadership for a transition to a managed care focus for DHS and serve as the primary point of contact with DHS' managed care plan partner(s);

- restructure and lead ongoing collaboration with the PPPs and other system partners;

- seek creative partners and strategies to enhance recruitment efforts for providers (and other hard-to-secure positions) to serve the DHS patient population, including, but not limited to, exploring opportunities such as loan repayments for primary care physicians who chose to remain in the system after completing their residencies;

- work with the DHS finance leadership to secure favorable arrangements (such as Federally Qualified Health Center status) to help sustain the system's ambulatory services; and

- plan for, secure and monitor primary, specialty and managed care infrastructure needs for the system.

- Identify the Medical Homes—and the operational and practice infrastructure to support them—for a defined population of 400,000-450,000 patients that DHS will manage in its system, expanded to include the Public Private Partner (PPP) clinics. This managed population will include Medi-Cal patients, enrollees in the Coverage Initiative that will convert to Medi-Cal or insurance under Health Reform, IHSS workers and those that will remain uninsured but will require management to assure effective use of resources within DHS. Further, it is critical to understand that there will be a set of services, predominately urgent care, that will need to be made available and, in some cases, developed, for patients who will utilize the system more episodically. Specifically, the Medical Homes within DHS will include:

    - primary care medical homes within DHS and through the PPPs, whose inclusion in the DHS system is critical to meeting demand;

    - "enhanced" Medical Homes within DHS, most likely within the CHCs, with additional specialty services to meet the needs of more complex patients; and

    - "specialized" medical homes within DHS focusing on patients with co-morbidities utilizing a high degree of specialty care and SPDs, including people with disabilities and those with behavioral health issues, particularly building upon the unique opportunities inherent in expanding the outpatient services and partnerships affiliated with Rancho Los Amigos Medical Center.

- Assure that accessible, timely and appropriate specialty outpatient care—a critical component of service for the SPD and chronically ill population that will transition into the Coverage Initiative and, under Health Reform, into Medi-Cal—is planned for and made available to the patients managed by DHS. Specifically, DHS must:

    - determine what scope and volume of specialty services should be available to the defined population;

    - ensure full utilization of specialty services—including outpatient surgery-at all DHS sites;

    - assure that current DHS specialty services are appropriately utilized and full capacity is made available;
    - create within the DHS agreements with medical schools a clearly delineated requirement for outpatient specialty services;

    - address the challenges for the delivery of specialty care within the teaching environment, which is the dominate model for specialty care outpatient activity in

DHS' hospital-based clinics, and develop and implement strategies for maximizing specialty care capacity in non-teaching environments like MACCs and CHCs;

- identify system-wide specialties (such as those provided by Rancho Los Amigos and the other DHS hospitals) that could serve all regions and set expectations and provide support for the availability to those services; and

- develop and implement a plan for filling existing gaps and eliminating duplications throughout the system to be able to meet access requirements under managed care.

- Assess diagnostic capacity throughout the DHS system and determine gaps and duplications based on anticipated need of the defined managed patient population. The plan should include those services offered at both DHS ambulatory centers and hospitals. It is conceivable that several ambulatory centers should be identified and built out as diagnostic hubs serving several regional DHS clinics as well as those PPPs related to the region.

- Integrate Management Services Organization (MSO) functions into the restructured Ambulatory Care services within DHS and secure a partnership to assure inclusion in and growth with a managed care plan or plans. Specifically, DHS should:

  - determine the capitation model or models that it will pursue for its services (recognizing that there may be differences depending on geographic and network challenges);

  - create (through a vendor relationship, at least initially) an MSO for DHS—and, perhaps, its PPPs—to oversee the transition of its operations to managed care readiness;

  - define its primary care, specialty, inpatient, SNF, DME, home health, hospice and diagnostic capacity and identify and address gaps for the defined managed population;

  - directed centrally, define the model for managed care leadership and structure at the regional network level (including PPPs);

  - assure, in collaboration with the CEO and Board of Supervisors, an ability to enter into, refine and terminate contractual agreements in a timely manner through increased delegated contracting authority and expedited contracting processes;

- identify operational infrastructure and delivery network priorities to support the transition of the DHS system to managed care (IT, utilization management, practice management, PPP integration, care management, specialty care enhancement, hospital partners to assure coverage and access, etc.);

- set a timeline to implement the above priorities based on the targets of both the California 1115 Waiver and Health Reform; and

- work with LA Care to transition patients out of the Community Health Plan (if negotiations are successfully completed) and reassign current CHP employees as possible.

How Do We Make This Happen?

One Year Work Plan

The following steps are priorities that must be taken within the next year to implement the restructured ambulatory care system:

- DHS should appoint, within 30 days, an ambulatory/managed care central leadership team with the authority to oversee and implement the work plan. While these positions may be interim, they should be appointed immediately, be relieved of other duties to devote full-time to this effort, given the stature on par with hospital leadership teams, and work with the Ambulatory Care Restructuring Steering Committee to implement the elements of the work plan. New positions should be created to assure that this effort is a permanent restructuring within DHS, not a temporary "project." The first iteration of the leadership team should include: a CEO, COO, CMO, Managed Care Director and CNO, as well as the staff necessary to support these positions. In addition, DHS staff from finance, human resources, IT, facilities management (to assure attention to the vast capital needs of the DHS ambulatory facilities) and planning should be identified who will be dedicated to support the creation of this new unit. Ambulatory-focused programs within the DHS (including PPP and Healthy Way LA) should be integrated into this new Division. Finally, the Office of the CEO should appoint a full-time liaison who will work with the new team to resolve any issues that involve the Board of Supervisors, contracting, interaction with County HR, or other County level issues.

- The DHS ambulatory/managed care leadership team should be charged to, within 30 days of their appointment, report back to the DHS Director with a detailed schedule of activities to be completed over the next year, consistent with this work plan. This focus should include aligning and integrating current DHS efforts related to ambulatory and managed care, clearly identifying responsibilities for accomplishing targets and, with the system leadership and defining the new division within a restructured DHS organizational chart that sets ambulatory/managed care at the same level as its hospitals.

- The DHS Ambulatory Restructuring Steering Committee should be kept in place over the next year to work in a transitional advisory role with the ambulatory leadership team to address and resolve key remaining issues, including (but not limited to):

  - assisting the leadership of DHS and the new ambulatory/managed care division with the organizational transition, including coordinating activities between DHS hospitals and ambulatory care areas of joint accountability;

  - monitoring and, as necessary, refining assumptions about the scope of the defined population to be managed by DHS;

  - establishing the care management model(s) for the systems defined population;

  - determining PPP and DHS roles in meeting the system's primary care Medical Home capacity needs;

  - defining options and priorities for financial incentivization of ambulatory care focused practice (within DHS and through the Coverage Initiative, PPP program, etc.);

  - assisting in the implementation of a system-wide review of DHS specialty capacity, starting with priorities for the defined population;

  - determining the scope of services that will be available for those patients likely to receive primarily urgent/episodic care, and collaborating with the system's EDs in determining policies for addressing the disposition of these patients;

  - recommending ambulatory-specific criteria for the negotiation of medical school agreements;

  - initiating priority pilots between DMH/DPH/DHS;

  - establishing a mechanism to assure accountability between DHS hospitals and ambulatory services;

- integrating managed care delivery system elements into DHS at the system, regional and facility levels; and

- assuring active operational participation in DHS planning efforts related to the 1115 Waiver and Health Reform.

- Initiate, within 30 days, Medical Home training in the DHS system through a collaborative model. Several sites (CHCs, MACCs, hospital-based specialty clinics, partner PPP) should be chosen to begin training for Medical Home readiness (paneling, care management integration, patient flow, quality, etc.). These initial sites will generate teams that will train others in DHS over the next months. It should be clear that this training will continue over at least the next year (and probably longer) and will need ongoing support and resources.

- Integrate, within 90 days, managed care delivery system infrastructure, secured through DHS negotiations with LA Care, into the restructured ambulatory care system. Priorities for the development of managed care infrastructure to be supported (either directly or through the provisions of resources) through negotiations with LA Care include:

  1) **Consultant assistance to DHS.** Priority areas for managed care-related consultation would include: Medical Home training throughout the system; conversion of finance approaches from fee-for-service to capitation and other managed care payment mechanisms; development of contracting models, delivery system planning and best practices in managed care delivery; communications messaging and dissemination to support the transition of the Department to a more patient-centered and managed-care focus.

  2) **Information Technology Support.** A priority list of IT requirements (including—but not limited to—disease registries, care management, practice management, utilization management (including concurrent review, prior authorization, referral management) and expanded communication bandwidth between the system's facilities for a sharing of medical information) should be generated by DHS focused on the delivery system requirements of managed care. Support from the Internal Services Department (ISD) will be required to accomplish some of these priorities.

  3) **Staff/leadership.** There may be holes in the current staff available to DHS to make up its ambulatory/managed care leadership position that will need to be provided, at least short term, through a contractual relationship.

4) **MSO for the DHS.** DHS will need to secure an MSO to perform certain services for its delivery system in both preparing for managed care and performing the related ongoing operational functions (eligibility, concurrent review, appointment, care management, disease registry, claims management, contracting, pharmacy management, compliance, etc.). While this is optimally a function that will be built—all or in part—within the DHS, these services will need to be established and aligned with the new division as soon as possible...

- Implement, within 30 days, a comprehensive communication plan describing the transition to the new ambulatory/managed care structure. The transition from a delivery system that is heavily focused on episodic care for patients that come through its EDs to one that is patient-centered and focused on providing patients, as much as possible, a comprehensive system of care based in primary care medical homes and involves partnerships with other providers is a dramatic change for DHS. Early and ongoing communication to and with key stakeholders (DHS administration and front line staff, physicians and medical schools, provider partners, unions, the Board of Supervisors and other County departments, relevant state and federal authorities, the community at large and, most importantly, DHS patients) will be vitally important as this transformation progresses. DHS should secure consulting assistance in establishing and disseminating its message and tailoring it specifically to individual stakeholders.

- Initiate, over the next year but starting immediately through a collaborative and focused effort, the transition to a standardized ambulatory staffing model that assures greater efficiency and effectiveness in the DHS ambulatory settings. Work is already well underway to both assess the current staffing in DHS clinics and target activities that will transition the department to greater consistency, productivity and effectiveness. The work to date—which has focused on the primary care services delivered within the Department, has preliminarily concluded that there may be the capacity (both with current space and current providers) to increase the number of patient visits generated and, with additional providers, to achieve even greater capacity increases. A major component in achieving this increase, however, is a redesign of the staffing model. Based on work done to date and work projected for the future, it is recommended that DHS:

  - seek and receive acceptance of the new staffing model for primary care from the Office of the CEO and initiate the transition process under the direction of the ambulatory leadership team;

  - work with HR and the CEO to create the job classification for "Certified Medical Assistant" (CMA), a position that will play a significant role in the clinic staffing model;

  - work with HR and the CEO to redesign current job descriptions to meet the specific needs of the ambulatory environment (i.e., nurses moving into care management—

a job description that will need to be developed when the care management model is defined);

- address the current difficulty in recruiting newly trained primary care physicians by granting the DHS CMO the authority to authorize the advanced step placement for these physicians to close the market disparity gap and allow a competitive salary for these critical positions;

- involve the unions in position redesign efforts;

- identify training needs and secure resources to facilitate the transition to new job descriptions and staffing models;

- start to implement the new staffing model in DHS primary care clinics this year;

- complete the staffing model analysis for DHS specialty clinics during the next three months; and

- move toward the creation of panels and team-based care in DHS clinics.

- Evaluate short and long term IT solutions. While the evolution to a common Electronic Health Record (EHR) is critical, there are short-term initiatives that can significantly improve DHS' ability to manage a defined population and enhance the communication between system providers and should be initiated. Issues which must be addressed include developing the capacity to assign and manage panels of patients for primary care providers. DHS must either significantly redesign or replace the current DHS specialty referral system (RPS). to support managed care requirements for timely and appropriate access to specialty services will be critical as complex patients move into managed care. In addition, DHS and ISD should work to establish robust linkages between DHS facilities for a medical information exchange system. Disease registries should be evaluated and secured. Any long-term solutions should be thoroughly evaluated for both their ambulatory effectiveness and their potential for connectivity to other provider partners.

- Implement a new relationship with the PPPs, resulting in a strong and integrated alliance with the DHS system, particularly focused on preparation for the California 1115 Waiver and Health Reform. These discussions should include:

  - integrating approaches to the Coverage Initiative population, SPD managed care and current Medi-Cal managed care patients assigned to the PPPs who could better utilize the DHS specialties and hospitals;

- moving toward risk-adjusted capitation payments for the uninsured patients assigned to PPPs, aligning with the approach taken for the Medi-Cal population;

- restructuring the assignment of PPP patients to better meet the needs of the DHS system to assure that they have primary care providers for their patients inappropriately utilizing EDs or specialty clinics who should be in Medical Homes;

- exploring joint approaches to managed care (including management services) and IT infrastructure; and

- establishing a formal process for ongoing assessment and joint planning for the future.

- Begin a specialty care capacity assessment process at all DHS specialty care sites (hospitals, MACCs, CHCs). Starting with those specialty services in greatest demand by the primary care system (including PPPs), the process should review current utilization for appropriateness (including chart reviews) and assess the existing referral system and procedures and make changes to assure greater efficiency.

- The DHS medical school agreements should be reviewed and a plan developed to assure that ambulatory services required by the system are supplied (or a mechanism established to allow them to be attained elsewhere). This process should begin immediately.

- Escalate discussions with DMH/DPH regarding pilots integrating medical and behavioral health services. Finalize the development and implementation of the collaborative project with DMH to provide integrated and coordinated prevention and early intervention mental health services at selected DHS MACCs and CHCs. Collaborate with DMH and DPH to develop integrated models for physical and behavioral health services under the renegotiated 1115 Waiver, whose implementation plan calls for integrated models by January 2011.

- Prioritize ambulatory/ managed care inclusion in the DHS Strategic Planning process. Develop and implement a strategic plan for DHS as an integrated and coordinated delivery system that provides care using managed care principles. The strategic plan should include input from internal and external stakeholders and be consistent with the California 1115 Waiver and national health reform. The strategic plan should pay particular attention to the transformation of the DHS ambulatory care system and its relationship with all of the other components of the health care delivery system.

Health Services
LOS ANGELES COUNTY

October 3, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON NEGOTIATIONS WITH L.A. CARE**

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

John F. Schunhoff, Ph.D.
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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

On April 13, 2010, your Board approved, in concept, the report and recommendations by Health Management Associates (HMA) on its evaluation of the Department of Health Services (DHS) Office of Managed Care (OMC)/Community Health Plan (CHP) and its readiness for pending health reform changes. In addition, your Board approved the Chief Executive Office (CEO) convening DHS and L.A. Care Health Plan (L.A. Care) representatives to engage in negotiations to determine whether the new relationship, as outlined in the HMA report, could be developed.

Since then, the CEO and DHS have provided reports on the L.A. Care negotiations, on the ambulatory care transformation, and on the new 1115 Waiver. This is to provide you with an update specific to the L.A. Care negotiations.

Background and Key Board Actions

On March 1, 2011, your Board approved a recommendation to negotiate and execute Medi-Cal Managed Care provider agreements with L.A. Care for Seniors and Persons with Disabilities (SPDs), effective March 1, 2011 through September 30, 2014, upon review and approval by County Counsel and the CEO, and with notice to your Board. Two provider agreements were negotiated and executed, effective May 1, 2011.

On March 29, 2011, your Board approved my policy recommendation that DHS transition the CHP staff to serve as the Medical Service Organization (MSO) for DHS, concentrate DHS resources on being the key provider of health care for Medi-Cal and uninsured populations in Los Angeles County, and transition all lines of business from the CHP to L.A. Care to assume all health plan functions, such transition occurring gradually, over the next year.

On July 26, 2011, your Board approved delegated authority for contractual actions necessary to transition the Medi-Cal Managed Care and Healthy

Families enrollees from CHP to L.A. Care, with the transition scheduled for January 1, 2012.

Transition of SPDs to Managed Care

SPDs are the first group for which the new relationship between DHS and L.A. Care was established. In this relationship, L.A. Care performs the health plan functions and DHS is a key safety net provider for the health plan. According to the State 1115 Waiver plan, the SPDs are being moved from fee-for-service to managed care over a twelve month period, starting June 1, 2011. Each month, L.A. Care receives an assignment of new patients and each month L.A. Care assigns a portion of those to DHS as their care provider. In the first four months of assignments, the net SPDs assigned to DHS (net of those who have subsequently transferred to other providers) is 12,200. This is 41% of the 30,000 target established in the agreement with L.A. Care.

The most challenging part of this has been the default assignments. At the State level, for enrollees who choose a health plan and/or provider, the State honors that choice. Enrollees who do not make a choice, are assigned by the State based on information about prior Medi-Cal fee-for-service provider use, family assignments, and geographic location. Unfortunately, over 60 percent of those enrolled to date state-wide have been simply default assigned to one of the health plans, in the absence of any useful information on the enrollee. When L.A. Care, in turn, assigns new enrollees to contracting health plans and physician groups, or to the County through L.A. Care's direct plan, a large percentage of the enrollees are default assigned, which means that DHS has been receiving members with no prior association with DHS.

L.A. Care and DHS have worked through the difficulties of the high percentage of default assignments. DHS asked L.A. Care to change its algorithm to lower the number of defaults to DHS. This is being closely monitored month to month. L.A. Care has also worked with DHS to reassign those members who, when they come to DHS, indicate that they want to continue to receive their care from a provider who is in another plan or physician group under L.A. Care.

Medi-Cal Managed Care

DHS and L.A. Care completed the negotiations concerning amendments to the SPD provider agreements, necessary to transition existing Medi-Cal managed care enrollees from CHP to L.A. Care on January 1, 2012. The amendments were signed September 30, 2011, effective October 1, 2011, and L.A. Care has begun to assign non-SPD new Medi-Cal enrollees to DHS as a provider in October, rather than CHP as a health plan. Existing Medi-Cal managed care enrollees in CHP will be transitioned to L.A. Care on January 1, 2012.

Healthy Families

DHS and L.A. Care met with the California Major Risk Medical Insurance Board (MRMIB) to discuss the transition. MRMIB staff strongly recommended that the transition of the CHP

Healthy Families enrollees to L.A. Care occur on September 30, 2012, because CHP has the preferred community provider plan designation for the contract year starting October 1, 2011, and there is no established mechanism for transferring it mid-year to L.A. Care. This designation gives CHP's Healthy Families enrollees a discount on their premiums. L.A. Care can apply for this designation in the Spring of 2012, competing with other plans, and would likely receive this designation effective October 1, 2012, given the role of DHS in its network. This means that CHP must continue as an operating Knox-Keene licensed health plan through September 30, 2012.

In the meantime, in order to facilitate the transition of CHP staff to an MSO function, we will negotiate an interim agreement for L.A. Care to do the administrative health plan functions for CHP from January through September 2012. We plan to bring this agreement to your Board for approval in October.

In Home Supportive Services

The CEO, DHS, the Department of Public Social Services (DPSS), L.A. Care and the Personal Assistance Services Council (PASC) have held several meetings to discuss the transition of the IHSS health plan from CHP to L.A. Care, effective January 1, 2012. Delegated authority for contractual actions necessary to transition the IHSS enrollees is contained in a separate forthcoming Board letter, which we expect to file for your consideration in October.

The IHSS health plan is currently structured and organized through a complex set of inter-related agreements and MOUs and financial transactions which must be amended. Most of the care is provided in DHS facilities. The transition should be nearly transparent to IHSS enrollees, as their providers and network will not change.

Long-Term Financial Relationship

The negotiators are completing negotiations for the terms of an agreement which will serve as the long-term framework of the financial relationship between L.A. Care and the County, as the key safety net provider in the County. This agreement, which will be recommended in a separate Board letter, will include the ongoing use of cost-savings from the transition of all health plan functions from DHS (CHP) to L.A. Care to support the County safety net system. We will file this Board letter concurrent with the IHSS Board letter.

If you have any questions or need additional information, please contact me at (213) 240-8101.

MHK:JFS:jp

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Public Social Services

Health Services
LOS ANGELES COUNTY

Los AngelesCounty
Board of Supervisors

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

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February 22, 2012

TO: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON NEGOTIATIONS WITH L.A. CARE**

On April 13, 2010, your Board approved, in concept, the report and recommendations by Health Management Associates (HMA) on its evaluation of the Department of Health Services (DHS) Office of Managed Care (OMC)/Community Health Plan (CHP) and its readiness for pending health reform changes. In addition, your Board approved the Chief Executive Office (CEO) convening DHS and L.A. Care Health Plan (L.A. Care) representatives to engage in negotiations to determine whether the new relationship, as outlined in the HMA report, could be developed.

Since then, the CEO and DHS have provided reports on the L.A. Care negotiations, on the ambulatory care transformation, and on the new 1115 Waiver. This is to provide you with an update specific to the L.A. Care negotiations, to report on progress since the October 3, 2011 status report.

Transition of SPDs to Managed Care

SPDs are the first group for which the new relationship between DHS and L.A. Care was established. In this relationship, L.A. Care performs the health plan functions and DHS is a key safety net provider for the health plan. According to the State 1115 Waiver plan, the SPDs are being moved from fee-for-service to managed care over a twelve month period, starting June 1, 2011. Each month, L.A. Care receives an assignment of new patients and each month L.A. Care assigns a portion of those to DHS as their care provider. In the first nine months of assignments, the net SPDs assigned to DHS (net of those who have subsequently transferred to other providers) is 20,514. This is 68% of the 30,000 target established in the agreement with L.A. Care.

The most challenging part of this continues to be the default assignments. At the State level, for enrollees who choose a health plan and/or provider, the State honors that choice. Enrollees who do not make a choice, are assigned by the State based on information about prior Medi-Cal fee-for-service provider use, family assignments, and geographic location. Unfortunately, over 60 percent of those enrolled to date state-wide have been simply default assigned to one of the health plans, in the absence of any useful information on the enrollee. When L.A. Care, in turn, assigns new enrollees to contracting health plans and physician groups, or to the County through L.A. Care's direct plan, a large percentage of the enrollees are default assigned, which means that DHS has been receiving members with no prior association with DHS.

L.A. Care and DHS have worked through the difficulties of the high percentage of default assignments. DHS asked L.A. Care to change its algorithm to lower the number of defaults to DHS. This is being closely monitored month to month. Since members have the right to maintain their relationship with an existing Medi-Cal provider for up to 12 months, L.A. Care has also worked with DHS to reassign those members who, when they come to DHS, indicate that they want to continue to receive their care from a provider who is in another plan or physician group under L.A. Care.

Medi-Cal Managed Care

DHS and L.A. Care completed initial negotiations concerning amendments to the SPD provider agreements necessary to transition existing, Medi-Cal managed care enrollees from CHP to L.A. Care on January 1, 2012. The amendments were signed September 30, 2011, effective October 1, 2011, and L.A. Care began to assign non-SPD new Medi-Cal enrollees to DHS as a provider in October, rather than CHP as a health plan. 132,000 existing Medi-Cal managed care enrollees in CHP were transitioned to L.A. Care on January 1, 2012, of which 44,700 were assigned to DHS for their primary care home.

Healthy Families

DHS and L.A. Care met with the California Major Risk Medical Insurance Board (MRMIB) to discuss the transition. MRMIB staff strongly recommended that the transition of the CHP Healthy Families enrollees to L.A. Care occur on September 30, 2012, because CHP has the preferred community provider plan designation for the contract year starting October 1, 2011, and there is no established mechanism for transferring it mid-year to L.A. Care. This designation gives CHP's Healthy Families enrollees a discount on their premiums. L.A. Care will apply for this designation in the Spring of 2012, competing with other plans, and will likely receive this designation effective October 1, 2012, given the role of DHS in its network. This means that CHP must continue as an operating Knox-Keene licensed health plan through September 30, 2012.

In the meantime, in order to facilitate the transition of CHP staff to an MSO function, we negotiated an interim agreement for L.A. Care to do the administrative health plan functions for CHP from January through September 2012. In addition, Healthy Families was added as a "product line" to the provider agreement so that new enrollees in Healthy Families can choose to be assigned to DHS facilities as their medical home, when choosing L.A. Care as their health plan.

In Home Supportive Services

The CEO, DHS, the Department of Public Social Services (DPSS), L.A. Care and the Personal Assistance Services Council (PASC), negotiated the agreements necessary to implement the transition of the IHSS health plan from CHP to L.A. Care, effective February 1, 2012. Most of these agreements are executed. The transition which occurred was nearly transparent to the 40,000 IHSS enrollees, as their providers and network did not change.

Long-Term Financial Relationship

The negotiators completed negotiations for the terms of an agreement [Community Health Plan Transition and Safety Net Support Agreement], which will serve as the long-term framework of the financial relationship between L.A. Care and the County, as the key safety net provider in the County. Notice of intent to execute this agreement was sent to your offices on February 14, 2012 and the agreement was executed February 21, 2012.

Completion of Initial Phase of Negotiations

Completion of negotiation on the various programs described marks the end of the initial phase of negotiations. For those programs, we move fully into the implementation phase.

Contractually, the relationship of the County with L.A. Care consists of:

1. Provider agreement covering the following programs, under which DHS is assigned L.A. Care members to have their medical homes at DHS:
    a. Medi-Cal Managed Care SPD
    b. Medi-Cal Managed Care non-SPD
    c. Healthy Families
    d. In-Home Supportive Services Health Plan

2. Community Health Plan Transition and Safety Net Support Agreement, which frames the long-term financial relationship between L.A. Care and the County, with an initial term of 10 years.

3. Agreements of DPSS and PASC with L.A. Care to implement the IHSS Health Plan.

One contractual issue which is outstanding is an agreement on the terms under which L.A. Care could have access to DHS specialty care for L.A. Care members who are receiving their primary care elsewhere in L.A. Care.

Long-Term Operational Partnership

Now that the Transition and Safety Net Support Agreement is complete and the initial provider agreement sections for each program are done, DHS and L.A. Care can focus our collective efforts towards strengthening this partnership with a continued focus on directing available resources towards patient care and maximizing operational efficiencies. We will also continue to support each other's efforts to strengthen the safety-net system. eConsult is an early example of the collaborative effort between L.A. Care, Community Partners and DHS to transition to an improved platform for referrals from safety-net primary care providers to specialists.

Next Steps

It is important to emphasize that the provider agreement will be regularly amended going forward as opportunities to improve operational efficiencies arise and at least every time the State changes the rates it pays for one of the specific programs. It will also need amendment when the final processes for financing the SPDs are negotiated with the State.

Assuming that the State continues with its intent to bring the dual eligibles (Medicare - Medi-Cal) into Medi-Cal Managed Care, a provider agreement amendment for that population will be needed, as well as any necessary contractual arrangements related to the IHSS program.

If you have any questions or need additional information, please contact me at (213) 240-8101.

MHK:JFS:jp

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Public Social Services
Mental Health